vanco orthodontics

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Dental Board Consultations
AHPRA
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Re: Scope of Practice Admission

Dear Sir/Madam,

The proposed changes to the already flawed Scope of practice registration standard and Guidelines for scope of practice do nothing to enhance the welfare of dental patients, and in my opinion they increase the risk of poor treatment outcomes.

They do not assist the public to understand who is the most appropriate practitioner to provide certain treatments.

Guidelines are needed to clarify the appropriate scope of practice for each group of practitioners, for dental practitioners and the public. The Board's proposed changes do not provide this.

The current Scope of Practice Registration Standard and Guidelines for Scope of Practice

The current Standard and Guidelines encompass the illogical position that for regulatory purposes, the scope of practice for a general dentist and specialist dentist is the same. No distinction is made between the scope of a qualified post-graduate student who graduates with three extra years of training and a general dentist graduate.

The number of general dentists incorporating orthodontics in their practice is increasing. This has been fuelled by a rapid growth in the profitable, but unregulated, CPD course market and the "post graduate diploma"-style courses focused on orthodontics. Unfortunately, in my experience most of these courses are sadly lacking in terms of clinical training. The end result is often an over enthusiastic, but poorly trained practitioner.

At present no accredited general dental training program in Australia teaches the use of full fixed orthodontic appliance therapy, nor clear aligner treatment. In my experience, a significant percentage of general dental practitioners who are incorporating fixed orthodontics and clear aligner treatment within their general practices are practising outside their trained scope of competencies.

I see evidence of this through:

- Fellow ASO members reporting larger numbers of orthodontic transfer patients from GP practitioners for retreatments or remediation of failed treatments; I too have had first-hand experience with regard to this just like my ASO colleagues.
- Indemnity insurers requiring general dentists doing orthodontics to pay an increased premium;
- Indemnity insurers stating that the number and value of orthodontic claims are rapidly rising; and
- The increase in GP practices promoting and advertising themselves as providers and sometimes "specialists" in braces/aligner treatment and other non-traditional quasi-scientific orthodontic treatment techniques learnt on weekend courses, "mini-residencies" and other short courses.

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- Furthermore, in conversations that I've had with GP practitioners, almost all believe that when they're doing an Invisalign (or Clear Correct) case for instance, that Invisalign is doing the treatment planning for them. This is clearly not the case, as Invisalign is a digital lab, which makes aligners based on a prescription from the practitioner. The prescription from the practitioner, should be based on a plan which gives the best balance of dental and facial aesthetics, occlusion, stability and preservation of the dentition. This observation is alarming as without appropriate treatment planning, there is very high risk of moving teeth in appropriate positions, leading to iatrogenic tooth loss and hence harm to the public.

Removal of "independent practitioner" and "structured professional relationship" requirements

As a member of the Australian Society of Orthodontists (ASO), I've been advised that the ASO has grave concerns that the removal of the requirements of an 'independent practitioner' and the structured professional relationship. Coupled with relying on dental practitioners to self-assess that they have sufficient training and/or qualifications when moving into a new area of practice would be risking public welfare. This is often the welfare of minors given the age of most patients undertaking orthodontic treatment.

Without any clear guidance as to what is "competence" in orthodontics, dental practitioners are unable to know what they do not know.

The ASO is also concerned that the revised Guidelines could be interpreted to enable the delivery of orthodontic treatment via allied health professionals. This may include the possibility for direct delivery of care or indirect delivery of care with and "consultant" or third parties directing care but being supervised by an external source.

Given treatment rarely progresses in a predictable systematic way, decisions have to made to constantly review the course of treatment. One of the advantages of a structured supervised postgraduate training of over 4500 hours is to provide the specialist with the necessary diagnostic skills to recognise subtle deviations from the proposed plan and make the necessary adjustments in a timely fashion.

Shortcomings resulting directly from delegation of orthodontic procedures to an oral health therapist without appropriate supervision by a qualified specialist, have reached the formal complaint process of AHPRA. This clearly reveals the fact that recognising variations in response is not part of the oral health therapist training program's foundation knowledge across Australia.

I am unsure why the Dental Board believes that the structured professional relationship requirement needs to be removed. I do not believe the structured professional relationship is hindering access to quality care. My view is that the structured professional relationship, team-based approach within dentistry is working well and should not be done away with.

The new reflective tool

In my view the proposed new reflective tool is fundamentally flawed.

All members of the dental profession need to understand their educational and training limitations as ultimately the public deserve an assurance that they are seeing and being treated by appropriately trained practitioners.

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It is not possible for an individual to “self-reflect” on their learning and assess their own capabilities because, quite simply, “they do not know what they do not know”.

A practitioner cannot know whether their knowledge is consistent with current evidence when they are not aware of it. This will be more pertinent, in the case of orthodontics, following a short course, or course with insufficient in-clinic hours.

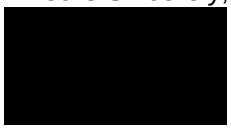
Human nature being what it is, I also suspect that those who have been inadequately trained are more than likely to self-assess competence due to being unaware of current evidence, let alone the gaps in their knowledge.

An untrained dental practitioner is not able to clearly distinguish between appropriate and inappropriate CPD, then reflect on whether the education has been appropriate to increase their Scope of Practice.

The role of the Dental Board of Australia and AHPRA is to protect the public from harm. These proposals run the risk of patient harm through a lack of appropriate and structured education, leading to an incorrect or incomplete diagnosis and subsequently inappropriate treatment.

In my view, the self-reflective tool adds nothing to the Scope Guidelines and if anything, further confuses an already problematic area.

Yours Sincerely,



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